IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 22, 2006

FILE COPY

Kayleen Parke, Administrator
Downey Care Center
PO Box 344
Downey, ID 83234

Dear Ms. Parke:

On August 8, 2006, a complaint investigation survey was conducted at Downey Care Center LLC. The survey was conducted by Rae Jean McPhillips, R.N. and Karen McDannel, R.N. This report outlines the findings of our investigation.

Complaint # ID00001677

Allegation #1: On July 18, 2006 at 7:15 p.m., a staff member was witnessed being verbally abusive towards a resident.

Findings: Based on interview it could not be determined that a staff member verbally abused the identified resident.

On August 8, 2006 between 8:30 a.m. and 9:00 a.m., three random residents stated staff were very good to residents. The residents interviewed stated they had not heard of any verbal abuse from staff, and would report verbal abuse to the administrator.

At 8:45 a.m., two caregivers stated they never heard other staff members raise their voices or be verbally abusive toward any residents in the facility.

At 11:00 a.m., the administrator stated she never heard staff be verbally abusive or raise their voices to residents in the facility. The administrator indicated one of the caregivers did have a louder voice when speaking, however, there had not been any other complaints from families or residents that the caregiver had been verbally abusive toward residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 8, 2006.

Allegation #2. The facility did not immediately take corrective action when an allegation of abuse was reported to them on July 18, 2006.

Findings: Based on interview and record review it could not be determined that the facility did not take immediate corrective action when the allegation of abuse was reported on July 19, 2006 at 6:30 p.m.

During an interview with the administrator on August 8, 2006 at 11:30 a.m., she stated the incident actually occurred on July 19, 2006 at approximately 6:00 p.m. She stated she received a phone call from a staff member at approximately 6:30 p.m. and was informed of a family member alleging verbal abuse. The administrator stated she spoke with the family member on the phone and gathered further information regarding the incident. The administrator re-assigned staff to care for the resident until she could return to the facility and conduct an investigation. The administrator interviewed all caregivers who were worked on July 19, 2006 during the afternoon and evening shifts. Additionally, the administrator stated she spoke with the identified caregiver when she returned to the facility onJuly 22, 2006. She said she reminded the caregiver to use a "softer" voice when speaking to residents. The administrator stated she had completed the investigation and was in the process of finishing the written investigation report.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 8, 2006.

Allegation #3: The facility did not seek emergency medical care when a resident (###) fell on July 19, 2006, and had a severely swollen arm that was hot to the touch.

Findings: Based on interview and record review it could not be determined the facility did not seek emergency treatment for the resident's severely swollen and hot to the touch arm.

Review of the facility's incident/accident reports revealed the identified resident sustained a fall on July 13, 2006 at 9:00 a.m. resulting in a bruise with a "blood blister" to her left arm. The incident report documented the facility contacted the nurse on July 13, 2006, and the nurse came to facility and assessed the resident. The record further documented the resident fell again on July 14, 2006, and sustained no further injury according to the nurse's notes.

During an interview with the administrator on August 8, 2006 at 9:30 a.m., she stated the identified resident's bruised arm was improving after her falls. She stated

she was working the night shift on July 21, 2006, when the resident's arm began swelling. "Her left arm started to swell before my eyes, at 3:30 a.m. her arm was so swollen I called the nurse and reported what was going on. The resident denied any pain in her left arm and did not want to go to the hospital. She was alert, eating and joking with me."

Review of the nurse's written report documented she assessed the resident and called the physician on July 21, 2006 at 10:00 a.m. The nurse's notes documented the physician was notified at 10:00 a.m. on July 21, 2006. The notes further documented the administrator called the nurse again on July 21, 2006 at 7:00 p.m. to see what else could be done for the resident. The nurse's notes documented, "Administrator called, informed her not much can be done with her edematous arm except to keep it elevated...."

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 8, 2006.

Allegation #4: The facility did not assist an identified resident with medication as perscribed by a physician, as she was overmedicated and was unresponsive from July 21, 2006 through July 24, 2006.

Findings: Based on interview and record review it could not be determined the facility did not assist the resident with medication as prescribed by a physician.

On August 8, 2006, review of the identified resident's "Summary Status Notes" documented the resident had family and friends at her bedside from July 21, 2006 through July 26, 2006. On the morning of July 21, 2006, staff documented the resident had a good appetite. On July 21, 2006, during the 2:00 p.m. - 10:00 p.m. shift, staff documented, family was at the identified resident's bedside, and assisted the resident to a recliner, "and she seemed more comfortable." On July 24, 2006 the record documented family at bedside, and two nurses were in the facility to see her.

The record contained the following physician's orders:

On July 24, 2006, the physician ordered, "Morphine 10 mg/ml (###) solution; Give 1/2 to 1 ml by mouth every 2-4 hours as needed."

The Medication Administration Record (MAR) documented the identified resident was given Morphine 0.5 ml for pain control on the following days and times:

July 24, 2006 at 5:30 p.m. and 9:30 p.m.
July 25, 2006 at 1:30 a.m., 5:30 a.m., 10:30 a.m., 2:30 p.m., 6:30 p.m. and 10:15 p.m.

July 26, 2006 at 2:30 a.m., and 6:30 a.m.

On August 8, 2006 at 11:30 a.m., the administrator stated, "the resident's health was declining, and the resident was no longer able swallow a pain pill by mouth. The physician changed the pain medication order from a pill to a liquid pain medication. Additionally, the administrator stated she and staff were repositioning the resident hourly and providing care. She said the resident would cry out in pain with the repositioning and cares, so medication was given to the resident prior to care and repositioning to decrease her pain.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on August 8, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

RAE JEAN MCPHILLIPS
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program